disorders, as the implications for service design and delivery seem to be – at least in our experience – different, for example at the primary care level.

Furthermore, when talking about the integration of mental health into primary care, it might be beneficial to allocate some attention to the way it is being done. Although implementation research is still ongoing, the Mental Health Gap Action Programme (mhGAP) Intervention Guide has been useful in training and supervising the primary care staff. However, to ensure the effective and sustainable integration of mental health within health systems, tools for the implementation and incorporation of the mhGAP within existing health systems are much needed. Such tools would help in the allocation of tasks/roles among different professionals at the primary care level, in the care packages and pathways for different disorders, in the health information system, and in the links of the primary care with specialized services.

A lot of attention is also needed for human resources. The tipping point in positive attitude change towards persons with mental disorders for many primary health care staff is often seen after they disclose a personal experience with mental health concerning themselves or a member of their family to an mhGAP supervisor and feel that the supervisor is able to listen and support. Addressing the mental health of the staff is a key action for integrating mental health into primary care and as such deserves closer attention.

A further factor to consider in order to enhance the integration of mental health into primary care is the use of innovations in domains such as management and information technology that have the potential to decrease cost and increase efficiency.

The third point highlights the importance of the context where persons with severe mental disorders live. Two main examples are prisons and humanitarian crisis. It might be a good idea if the framework delineated by Liu et al could include an item to highlight persons with severe mental disorders living in prisons as a vulnerable group in need of specific interventions. The same applies to persons with severe mental disorders living in humanitarian settings, where they are often either locked in big institutions or very disadvantaged in reaching the needed services, which in both cases will put them at a higher risk for premature death.

In summary, details pertaining to the implementation of the framework and to how it links to other mental health priorities are needed. This being said, this framework adds to the available tools and usefully highlights the importance of addressing the excess mortality in persons with severe mental disorders. In low-resource contexts – where mental health systems are under development with competing priorities – mental health disorder management, physical health treatment, screening for medical conditions, and stigma reduction interventions seem to be the components of the framework that would be easier and most important to consider, especially when the health system as a whole is fragmented or facing big challenges.

Finally, as mental health professionals and policy makers, we can learn a lot if we look to other disciplines and to emerging research in related fields, such as the newly published report "Insights for impact"[3]. This can help us increase the coherence of any model we propose with the bigger socio-political and technological world in which we live. Leveraging the knowledge we can gather on management innovations as well as latest evidence in human psychology and in mental health at the workplace, we can develop tailored interventions for health systems management and for the health workforce that would increase the engagement, well-being and efficiency of every health worker and of the system, helping them to achieve their goal of improving the health of the persons served.

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DOI:10.1002/wps.20379

# A service user's perspective

To address the alarming rate of excess mortality in persons with severe mental disorders (SMD), a multidimensional approach is the way to go, provided that communication and collaboration with the overall health system is effected and that it further extends to community-based, peer support and advocacy organizations which are providing psychosocial rehabilitation and support services.

Successful treatment of SMD does not merely rely on pharmaceutical intervention, but requires a holistic approach, one that specifically honors the entitlement of the rights of persons with mental disorders – the right to have access to quality health care services, have a good quality of life, enjoy life opportunities on an equal basis, and do so with dignity.

It is important to acknowledge the role that stigma plays in accessing health services and the severe neglect of mental health within the general health system. It is imperative that stigma reduction initiatives form an integrated component in all the suggested interventions and that mental health receive equal recognition as physical health.

Mental health services must provide a human rights focused approach that is perceived by persons with SMD as a means of care and support. Unfortunately, these services may present themselves as "punishment" in the sense of exposure to abusive attitudes and denying persons with SMD the right to participate in their treat-

ment and recovery plans. A system that does not recognize the "voice" of persons with SMD or acknowledges their views and opinions becomes an enforcer of disempowerment. Persons with SMD must be acknowledged as the key partners in scaling up mental health care services and reducing stigma. They must be empowered to a level where they can be actively involved in policy development, implementation and monitoring of health systems.

The Rural Mental Health Campaign in South Africa engaged with service users to assess the implementation of South Africa's Mental Health Policy Framework and Strategic Plan, and published the outcome in a report[1]. A service user from one of the participating rural communities confirmed the gap in acknowledging service users as key partners in improving mental health services, by stating: "People tend to disregard a mad person's opinions on issues of discussions". Service user engagement exercises conducted by the South African Federation for Mental Health further confirmed the experiences of service users who feel that they are often being denied the right to fully participate in their own treatment and recovery plans, that they are not taken seriously and that their views and opinions are often automatically dismissed.

General health workers need to receive adequate training in mental health related disorders, especially SMD, as part of their curriculum and become sensitized to the needs of persons with SMD, to eliminate attitudinal barriers that result in persons with SMD avoiding to seek services or failing to remain treatment compliant for both mental and physical health conditions. Some research studies conducted on the attitudes of health care workers towards persons with mental disorders interestingly indicated that they had less positive attitudes than the general public[2,3]. Another study showed that mental health care workers (registered nursing staff and medical orderlies) had both positive and negative attitudes towards persons with mental disorders, and suggested that mental health specific training (replacing myth with fact) can influence attitudes[4]. It is important to understand how these attitudes are formed to allow for the development of a targeted approach to educational initiatives, for health care service delivery to improve.

Community-based health care facilities or clinics need to move away from being "dispensers of medication", but rather become a "one-stop" service that accepts persons with SMD as equally deserving of all services available, a comprehensive package that looks at the person as a whole, as proposed by Liu et al's[5] multilevel intervention framework.

It is imperative to acknowledge peer and family support initiatives and service user groups as essential elements to the social model that focuses on eliminating systemic barriers, negative attitudes and exclusion by society, as stigma causes ripple effects in creating barriers in accessing services and life opportunities, further leading to human rights violations.

Considering that unemployment is a strong independent risk factor for increased mortality, it must be a vital target of interventions focusing at addressing socio-environmental determinants. Unemployment of persons with SMD is an issue that receives very little attention, yet it has an enormous impact on the lives of these persons – leaving them with feelings of worthlessness, inability to be independent and financially self-sustainable, and becoming isolated. Occupational therapists would be ideal to lead specific interventions to facilitate access to employment or supported employment, and assist persons with SMD in optimizing cognitive functioning and achieving independence as far as possible where they are able to take charge of their lives and invest in their overall health and mental wellbeing.

Health systems must collaborate with community-based organizations to create an effective and holistic service delivery platform for persons with SMD. If there is a disconnect between the two, it can cause great frustration to persons with SMD, who are trying to consolidate a treatment and recovery plan that is centered around their individual needs.

The aspiration of the Sustainable Development Goals of "leaving no-one behind" must be honored in the name of persons with SMD, especially in low-resourced or rural communities. "Rural-proofing" of policies[6] must be conducted to ensure that those communities are not left behind as they are most marginalized when it comes to accessing social and economic opportunities, including health care.

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DOI:10.1002/wps.20378

# Reducing premature mortality from non-communicable diseases, including for people with severe mental disorders

The Sustainable Development Goals approved by the United Nations General Assembly in 2015 include a specific target in goal 3.4 for non-communicable diseases (NCDs): by 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being[1]. This target aligns well with the paper